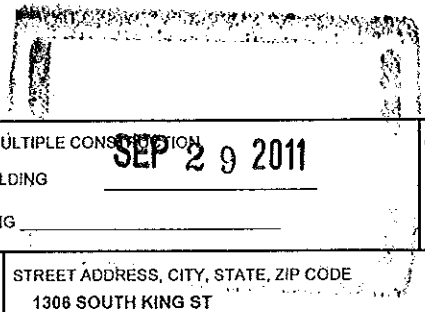


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/19/2011  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ <b>SEP 29 2011</b>	(X3) DATE SURVEY COMPLETED  09/09/2011
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NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HLTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1306 SOUTH KING ST WINDSOR, NC 27983
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to develop a care plan for a resident at risk for prevention of contractures for 1 (Resident #69) of 18 residents whose care plans were reviewed. Findings include:  Resident #69 was admitted to the facility on 05/11/09 with diagnoses of chronic kidney disease, osteoarthritis, congestive heart failure and hypertension.</p>	F 279	<p>F279</p> <p>A care plan for resident at risk for prevention of contractures was developed and placed in medical record for resident #69 09-09-11.</p> <p>All other residents with potential to be affected by the same alleged deficient practice have been identified through conducting a medical record audit. All residents with contractures and those at risk for contractures have a comprehensive care plan as appropriate. Resident referrals are made to the rehabilitation staff as appropriate and care plans updated to include appropriate interventions. Measures put into place to ensure the alleged deficient practice does not occur include: The interdisciplinary team members were in-serviced beginning 09-26-11 on comprehensive care plan requirements as outlines in RAI under F279. All new admissions will be screened and evaluated upon admission by the therapy department. All current residents will be reviewed daily at the morning meeting for any change of condition. The Director of Nursing or designee will conduct random medical record audits X 3 months to ensure the comprehensive care plans are in place. Any concerns found will be addressed with the interdisciplinary team and corrected immediately.</p>	<p>9-9-11</p> <p>10-7-11</p> <p>10-7-11</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Penny Brown</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9-29-11</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	<p>Continued From page 1</p> <p>A quarterly Minimum Data Set (MDS) assessment completed on 08/04/11 identified Resident #69 as having short term and long term memory impairment and having severe cognitive impairment for daily decision making. Resident #69 was documented as being dependant on staff for all activities of daily living and having functional limitations on both sides of upper and lower extremities. The assessment indicated Resident #69 did not reject care.</p> <p>An OCCUPATIONAL THERAPY EVALUATION reviewed indicated Resident #69 had received occupational therapy from 12/15/09 until 04/13/10 for a decline in functional status and contracture management. Under the Discharge Summary section, it documented in part: "tendency to keep upper extremities flexed at the elbow although staff able to extend the limbs when relaxed. Pt(patient) tolerating handroll up to 4 hours with handroll being applied (symbol used)(after) AM (morning) care by nursing."</p> <p>Review of Resident #69's current care plan, updated 08/04/11 did not address contractures or have any interventions in place.</p> <p>In an interview with the Rehab Manager on 09/09/11 at 8:52 AM, she said Resident #69 had a tendency to hold her arms up across her chest and her hands in a fist position. The Rehab Manager said she would expect a resident who did that to have some type of intervention such as a palm protector, hand roll, or soft hand orthotic to be put in place for the prevention of further contracture.</p> <p>During an interview with the Occupational</p>	F 279	<p>Medical record audit information is reviewed by the interdisciplinary team as part of the morning meeting to assure communication of findings and to make recommendations for follow-up. The Director of Nursing or Designee will review data for patterns/trends and report to the Quality Assessment and Assurance committee meeting monthly.</p>	10-7-11	
			<div style="border: 1px solid black; padding: 5px;"> <p align="center"><b>DISCLAIMER CLAUSE</b></p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p> </div>		

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F 279	Continued From page 2 Therapist (OT) on 09/09/11 at 10:08 AM she said a resident who clenched their hands in a fist position could become tighter if no interventions had been put in place.  In an interview with Nurse #2 on 09/09/11 at 10:35 AM, Nurse #2 said Resident #69 always held her arms bent upwards and her hands clenched in a fist position. Nurse #2 said she had not been aware of any interventions in place to prevent Resident #69's hands from becoming more contracted. Nurse # 2 said she had not seen any change in Resident #69's range of motion. Nurse #2 said she would expect to find any interventions on a residents care plan located on their chart.  During an interview with the Staff Development Coordinator on 09/09/11 at 11:50 AM, she said her expectation was if a resident held their hands in a clasped position, a therapy consult would be done and interventions would be put in place and be written on a residents care plan.  In an interview with the Minimum Data Set (MDS) Nurse on 09/09/11 at 1:30 PM she said a resident who holds their hands closed and is immobile would be at risk for contracture development. The MDS Nurse stated Resident #69 had contractures of her hands since admission. After review of Resident #69's care plan, the MDS Nurse said there were no specific interventions documented for the prevention of contractures.	F 279			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to	F 312	F312 Activities of Daily Living  The fingernails of resident #87 were trimmed and cleaned on 09-09-11.	9-9-11	

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F 312	<p>Continued From page 3</p> <p>maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and family and staff interviews the facility failed to provide fingernail care for 1 of 2 (Resident #87) sampled residents reviewed for Activities of Daily Living. Findings include:</p> <p>Resident #87 was re-admitted to the facility on 7/4/11 with cumulative diagnoses of cerebrovascular accident (CVA), Alzheimer's dementia and diabetes.</p> <p>Resident #87's quarterly Minimum Data Set (MDS) dated 8/15/11 indicated that Resident #87 had moderate cognitive impairment and was totally dependent for personal hygiene. Resident #87 did not reject care.</p> <p>Review of the facility Clinical Practice Standard "Routine Resident Care" revised in June 2008 states, "3. Daily personal hygiene minimally includes assisting or encouraging residents with washing their faces and hands, combing their hair each morning, and brushing their teeth and/or providing denture care. 5. Residents are encouraged or assisted with bedtime care that includes washing their faces and hands and putting on sleepwear."</p> <p>Review of the facility's Bed Bath handout revised April 2, 2011 states in the introduction that "A complete bed bath cleans the skin, stimulates</p>	F 312	<p>Residents with potential to be affected by the same alleged deficient practice have been identified through ongoing compliance rounds conducted by department managers. Measures put into place to ensure the alleged deficient practice does not occur include: Fingernails will be cleaned daily by resident care specialist during routine resident care. Fingernails will be trimmed twice a week and/or on an as needed basis. The Resident Care Specialist were in-serviced beginning 09-23-11 on Routine Resident Care to include the proper cleaning and care of resident's nails. New hires upon orientation will be oriented according to facility policy on Routine Resident Care</p> <p>The department managers complete rounds to monitor for trimmed and clean fingernails. Any concerns are addressed with the nursing staff and corrected immediately</p> <p>Compliance round information is reviewed by the interdisciplinary team as part of the Morning meeting Monday thru Friday to assure communication of findings and to make recommendations for follow-up. The Director of Nursing or Designee will review data for patterns/trends and report to the Quality Assessment and Assurance committee meeting monthly and adjustments made as needed based on identified trends.</p>	10-7-11	

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F 312	<p>Continued From page 4</p> <p>circulation, provides mild exercise, and promotes comfort. A partial bath -including hands, face, axillae, back, genitalia and anal region- can replace the complete bed bath for the patient with dry, fragile skin or extreme weakness."Under implementation it states, "If possible, soak the patient's hand in the basin (of water) to remove dirt and soften nails. Clean the patient's fingernails with the orangewood stick."</p> <p>Review of the Resident Care Cardex Worksheet used by the Resident Care Specialists (RCS) and dated 4/10/11, showed that nail care was to be provided by staff.</p> <p>Review of Resident #87's Care Plan for Activities of Daily Living (ADL) updated on 8/15/11, indicated that Resident #87 required staff assistance for completion of ADL needs.</p> <p>In an interview on 9/6/11 at 12:38 PM with a family member, it was stated that staff was not cleaning Resident #87's fingernails.</p> <p>In an observation on 9/6/11 at 12:50 PM Resident #87 was sitting up in a wheelchair in the small dining room. There was black matter observed under Resident #87's fingernails.</p> <p>In an observation on 9/7/11 at 12:22 PM Resident #87 was sitting up in a wheelchair in the small dining room. Resident #87's fingernails had dark matter under the nails.</p> <p>In an observation on 9/7/11 at 4:25 PM Resident #87 was lying in bed with eyes closed. Resident #87's hands were on top of the blanket and the fingernails had dark matter underneath them.</p>	F 312	<div style="border: 2px solid black; padding: 5px;"> <p align="center"><b>DISCLAIMER CLAUSE</b></p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p> </div>	

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F 312	Continued From page 5  In an observation on 9/8/11 at 8:25 AM Resident #87 was sitting up in a wheelchair at the bedside. Resident #87's fingernails were dirty with black matter underneath them.  In an interview on 9/8/11 at 8:30 AM with RCS #1, she stated that morning care included bathing, hygiene, mouth care, shaving and cleaning fingernails. She indicated that she had cared for Resident #87 during the three days of observation.  In an observation on 9/8/11 at 11:56 AM Resident #87 was sitting up in a wheelchair in the small dining room. Resident #87's fingernails had been cleaned. No black matter was noted underneath the fingernails. Resident #87 expressed pleasure that the fingernails had been cleaned.  In an interview on 9/8/11 at 2:27 PM with licensed nurse #1, she indicated that morning care consisted of bathing or showering, nail care, turning and repositioning and shaving. She stated that shaving and nail care should be done on a daily basis. She indicated that she monitored her residents for facial hair and dirty nails. She stated that she would not expect a resident to have had dirty nails for the three days of observation.  In an interview on 9/8/11 at 3:10 PM with RCS #2, she indicated that the RCS was responsible for doing nail care on their own residents as needed.  In an interview on 9/9/11 at 11:00 AM with RCS #3, she indicated that fingernails should be cleaned after bathing was done every day.	F 312		

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F 312	Continued From page 6 In an interview on 9/9/11 at 11:20 AM with licensed nurse #2, she stated that fingernails were cleaned during baths or when getting residents dressed. She indicated that anyone could clean fingernails at any time.  In an interview on 9/9/11 at 1:45 PM with the Director of Nurses (DON), she indicated that morning care consisted of checking the residents, getting up the early risers, bed baths, nail care, shaves, and dressing the residents. Night time care consisted of some of the same things as morning care including cleaning fingernails if they were dirty. If the same RCS was taking care of the resident for the three days of observation she would have expected the RCS to have cleaned the resident's fingernails at some time during those three days.	F 312			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to put in place interventions to prevent further decline in range of motion and contractures of the upper extremities of 1 (Resident # 69) of 3 residents reviewed for range of motion. Findings include:	F 318	F318  The facility put interventions in place for resident #69 to prevent further decline in range of motion and contractures of the upper extremities 09-08-11.	9.8.11	

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F 318	<p>Continued From page 7</p> <p>Resident #69 was admitted to the facility on 05/11/09 with diagnoses of chronic kidney disease, osteoarthritis, congestive heart failure and hypertension.</p> <p>A quarterly Minimum Data Set (MDS) assessment completed on 08/04/11 identified Resident #69 as having short term and long term memory impairment and having severe cognitive impairment for daily decision making. Resident #69 was documented as being dependant on staff for all activities of daily living and having functional limitations on both sides of upper and lower extremities. The assessment indicated Resident #69 did not reject care.</p> <p>An OCCUPATIONAL THERAPY EVALUATION reviewed indicated Resident #69 had received occupational therapy from 12/15/09 until 04/13/10 for a decline in functional status and contracture management. Under the Discharge Summary section, it documented in part: "tendency to keep upper extremities flexed at the elbow although staff able to extend the limbs when relaxed. Pt(patient) tolerating handroll up to 4 hours with handroll being applied (symbol used)(after) AM (morning) care by nursing."</p> <p>Review of Resident #69's current care plan, updated 08/04/11 did not address contractures or have any interventions in place.</p> <p>An observation was made of Resident #69 on 09/07/11 at 12:15 PM. Resident #69 had been sitting in a recliner chair in the television room. Resident #69's right arm was flexed at the elbow across her chest area and the left arm was drawn</p>	F 318	<p>Residents with potential to be affected by the same alleged deficient practice have been identified through conducting a medical record audit. All residents with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Resident referrals are made to the rehabilitation staff as appropriate and comprehensive care plans updated to include appropriate interventions. Measures put into place to ensure the alleged deficient practice does not occur include:</p> <p>The staff were in-serviced beginning 9-26-11 on F318 increase/prevent decrease in range of motion and all RAI requirements. All new admissions will be screened and evaluated upon admission by the therapy department and appropriate interventions put into place. All residents will be reviewed in the morning meeting for appropriate interventions, care plans updated and referrals made as needed.</p> <p>The Director of Nursing or designee will conduct random medical record audits X 3 months to ensure appropriate interventions are in place to increase range of motion and/or to prevent further decrease in range of motion. Resident referrals will be made to therapy as appropriate and care plans will be updated to include appropriate interventions. Any concerns found will be addressed with the interdisciplinary team and corrected immediately.</p>	10-7-11	10-7-11



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F 318	<p>Continued From page 8</p> <p>up to her neck area. Resident #69 had both hands in a fistted position.</p> <p>Another observation made on 09/08/11 at 9:10 AM, revealed Resident #69 to be sitting in a recliner in her room with both arms flexed at the elbows and drawn up across her chest area and both her hands closed in a fistted position.</p> <p>In an interview with Resident Care Specialist (RCS) #2 on 09/08/11 at 3:10 PM, RCS #2 said Resident #69 always held both of her arms bent up with her hands closed. RCS #2 said they had to open Resident #69's hands up in order to wash them but they could not open them up all the way. RCS #2 said she had not observed any changes in Resident #69's range of motion.</p> <p>During an interview with the Director of Nurses (DON) on 09/08/11 at 4:15 PM she stated it was her expectation that a resident who held their hands in a closed position to have hand rolls placed for the prevention of contractures. An observation was made of Resident #69 with the DON on 09/08/11 at 4:25 PM. The DON attempted to open Resident #69's left hand and Resident #69 said it was "stuck shut." The DON said she would have expected hand rolls to be present.</p> <p>In an interview with the Rehab Manager on 09/09/11 at 8:52 AM, she said Resident #69 had a tendency to hold her arms up across her chest and her hands in a fistted position. The Rehab Manager said she would expect a resident who did that to have some type of intervention such as a palm protector, hand roll, or soft hand orthotic</p>	F 318	<p>Medical record audit information is reviewed by the interdisciplinary team as part of the morning meeting to assure communication of findings and to make recommendations for follow-up. The Director of Nursing or Designee will review data for patterns/trends and report to the Quality Assessment and Assurance committee meeting monthly.</p>	10-7-11	

**DISCLAIMER CLAUSE**

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F 318	Continued From page 9 to be put in place for the prevention of further contractures.  During an interview with the Occupational Therapist (OT) on 09/09/11 at 10:08 AM she said a resident who clenched their hands in a fist position could become tighter if no interventions had been put in place.  In an interview with Nurse #2 on 09/09/11 at 10:35 AM, Nurse #2 said Resident #69 always held her arms bent upwards and her hands clenched in a fist position. Nurse #2 said she had not been aware of any interventions in place to prevent Resident #69's hands from becoming more contracted. Nurse # 2 said she had not seen any change in Resident #69's range of motion.  During an interview with the Restorative Aide on 09/09/11 at 10:55 AM, she said Resident #69 had been on restorative care at one time for hand roll placement but was unable to recall when and why she had no longer been working with her.	F 318		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a	F 329	F329  On 9/09/11 the physician for resident #57 was notified of unnecessary medication and the need to utilize a PRN (as needed) anti-anxiety medication for sporadic behaviors and trial reductions. An order was obtained for a gradual dose reduction on 09-27-11.	9-9-11 9-27-11

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F 329	Continued From page 10 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, pharmacist interview, staff interview, and record review the facility failed, for 1 of 10 sampled residents (Resident #57) reviewed for unnecessary medications, to utilize a PRN (as needed) anti-anxiety medication for sporadic behaviors, instead initiating the use of an antipsychotic medication twice daily without a gradual dose reduction (GDR) in ten months of use. Finding include:  A preliminary hospital Discharge Summary documented Resident #57 was admitted to the hospital on 07/06/10 and was to be discharged with the diagnoses of cerebrovascular accident with right hemiplegia, ischemic cardiomyopathy, and carotid artery stenosis. The resident was not to be discharged on any psychoactive medications.  Resident #57 was admitted to the facility on	F 329	Additional measures put into place to assure the same alleged deficient practice does not recur are as follows: A chart audit was completed for all residents receiving anti-psychotic medications by consulting pharmacist on 9/13/11. All residents on anti-psychotic medications have appropriate physician orders and updated care plans, along with proper documentation for continued need or changes based on resident's episodes of behaviors. All residents with sporadic behaviors were reviewed for changes from scheduled medications to PRN.  Staff was in-serviced beginning 9-23-11 on the Psychotropic Management system and the appropriate documentation in Care Tracker and on the behavior sheets for all psychotic medications. All physician orders for anti-psychotic therapy will be reviewed during the morning meeting and with the Interdisciplinary Team for appropriate behavioral interventions. All new admissions with anti-psychotic medications will be assessed and will have behavior sheets placed on the MAR upon admission and resident entered into Care Tracker for proper documentation.	10-7-11 10-7-11

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F 329	<p>Continued From page 11</p> <p>07/20/10 with additional diagnoses of anxiety, mental disorder, and hearing loss. The resident was not admitted to the facility on any psychoactive medications.</p> <p>On 07/22/10 care plans were created for Resident #57 to address Depression/Anxiety/Sad Mood related to crying/stroke diagnosis and Behavior Symptoms related to verbal abuse/new environment.</p> <p>Review of Resident #57's Nursing Daily Skilled Summary notes for 7/26/10 through 9/30/10 revealed no behaviors were documented, and boxes for Psychoactive Medications Required or Behavior Issues were not checked.</p> <p>A 07/27/10 Social Progress Note documented Resident #57 was crying and exhibiting verbal abuse.</p> <p>A 08/09/10 Social Progress Note documented Resident #57 was being monitored for crying and behavior issues.</p> <p>A 09/14/10 Social Progress Note documented the resident was not exhibiting any mood or behavior problems. All further Social Progress Notes failed to document the existence of any mood or behavior problems.</p> <p>A 10/03/10 physician's order began the as needed (PRN) administration of Alivan 1 milligram (mg) to Resident #57 for agitation.</p> <p>Review of Resident #57's Medication Administration Records (MARs) the resident received 1 mg of PRN Alivan on 10/03/10, but</p>	F 329	<p>The Director of Nursing or designee will conduct chart audits monthly X 3. The pharmacy consultant and the Director of Nursing or designee will review residents on anti-psychotic medications on a monthly basis. The Director of Nursing or designee will follow up with each physician based on pharmacy recommendations. Gradual drug reduction based on the resident's behaviors will be implemented as needed.</p> <p>The results of the anti-psychotic medication audits and any negative findings during the consultant pharmacists monthly review will be taken to the Quality Assessment and Assurance Committee meeting for review monthly times 3 months and to the Medication Management Advisory Committee quarterly for appropriate.</p>	10-7-11 10-7-11

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F 329	<p>Continued From page 12</p> <p>received no more PRN Ativan the remainder of October 2010 through December 2010. Resident #57's January 2011 MAR could not be found in her medical record or thinned record material.</p> <p>The resident's 10/28/10 Quarterly Minimum Data Set (MDS) documented the resident had short and long term memory impairment, and exhibited no delirium, mood problems, psychosis, behavioral symptoms, rejection of care, or wandering.</p> <p>Review of Resident #57's Nursing Daily Skilled Summary notes for 11/04/10 through 12/04/10 revealed no behaviors were documented, and boxes for Psychoactive Medications Required or Behavior Issues were not checked.</p> <p>A 12/04/10 interdisciplinary Post Fall Review documented, " Resident (#57) fell (on 12/04/10 at 6:10 AM) while attempting to walk from w/c (wheelchair) to bathroom. Resident's first fall since admission. Recommended intervention: clip alarm to w/c...."</p> <p>A 12/04/10 11:00 AM telephone order from Resident #57's primary physician began the resident on Haldol 1 mg twice daily.</p> <p>12/08/10 Nurse's Note documented, "IDT (interdisciplinary team) review of fall on 12/04/10. No injury apparent. IDT recommended clip alarm to w/c. Res (resident) became very agitated, screaming and crying. Res took clip alarm several times and throw alarm in floor. Clip alarm removed from w/c and res became calm. Staff to monitor res for safety."</p>	F 329	<div style="border: 2px solid black; padding: 5px; text-align: center;"> <p><b>DISCLAIMER CLAUSE</b></p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p> </div>		

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F 329	<p>Continued From page 13</p> <p>Resident #57's January 2011 Behavior Monitoring Form documented the resident was being monitored for increased agitation and refusal of care, but failed to exhibit these behaviors.</p> <p>The resident's 01/13/11 Psychoactive Medication Evaluation documented dementia with behavior disturbances (increased agitation, refusing care, hard to redirect) justified the use of Haldol.</p> <p>On 01/13/11 "_____" (name of Resident #57) requires administration of psychoactive medication due to dementia with (symbol used) behavior disturbances" related to increased agitation, refusing care, and hard to redirect (crying/whining) was identified as a care plan problem. Interventions to this problem included "Periodic reviews of medications by interdisciplinary team to determine potential dose reductions" and "Psych (psychiatric) services as ordered". (Review of Resident #57's active medical record and thinned record material revealed the facility did not send the resident out for a psychiatric consult).</p> <p>The resident's 01/19/11 Quarterly MDS documented the resident had short and long term memory impairment, felt tired or with little energy, and exhibited no delirium, psychosis, behavioral symptoms, rejection of care, or wandering.</p> <p>Review of Resident #57's February 2011 and March 2011 MARs revealed the resident did not receive any prn Ativan, but continued to receive Haldol twice daily.</p> <p>Resident #57's February 2011 Behavior Monitoring Form documented the resident was</p>	F 329		

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F 329	<p>Continued From page 14</p> <p>being monitored for increased agitation and her March 2011 Behavior Monitoring Form documented she was being monitored for whining, but failed to exhibit these behaviors.</p> <p>On 03/28/11 "Exhibition of Behavioral Symptoms as evidenced by: socially inappropriate/disruptive behavior, resists care. Target behaviors indicated include: increased agitation, crying/whining, refusing care, and hard to redirect related to diagnosis" was identified as a problem on the resident's care plan. Interventions to this problem included "Administer medications as ordered, observe for effectiveness and side effects."</p> <p>The resident's 03/30/11 Psychoactive Medication Evaluation documented dementia with behavior disturbances (increased agitation, refusing care, hard to redirect) justified the use of Haldol.</p> <p>The resident's 03/31/11 Quarterly MDS documented the resident had short and long term memory impairment, felt tired or with little energy, had a poor appetite, had trouble concentrating on things, and exhibited no delirium, psychosis, behavioral symptoms, rejection of care, or wandering.</p> <p>Review of Resident #57's April 2011 through June 2011 MARs revealed the resident did not receive any prn Ativan, but continued to receive Haldol twice daily. Staff documented on the June 2011 MAR that the administration of PRN Ativan was discontinued on 06/08/11.</p> <p>Resident #57's April 2011 Behavior Monitoring Form documented the resident was being</p>	F 329		

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F 329	<p>Continued From page 15</p> <p>monitored for increased agitation and refusal of care, her May 2011 Behavior Monitoring Form documented she was being monitored for paranoia, and her June 2011 Behavior Monitoring Form documented she was being monitored for increased agitation and yelling/crying. However, the resident failed to exhibit any of these behaviors.</p> <p>The resident's 06/01/11 Psychoactive Medication Evaluation documented dementia with behavior disturbances (increased agitation, refusing care, hard to redirect) justified the use of Haldol.</p> <p>The resident's 06/02/11 Annual MDS documented the resident suffered from moderate cognitive impairment, had trouble concentrating on things, and exhibited no delirium, psychosis, behavioral symptoms, rejection of care, or wandering.</p> <p>In a 06/09/11 Consultation Report the facility's Consultant Pharmacist documented, "Comment: ____ (Resident #57's name) has taken Haloperidol (Haldol) 1 mg twice a day for behavioral symptoms related to dementia since 12/06/10. Staff reports that resident is experiencing no agitation or behavioral symptoms. Recommendation: For the initial attempt at gradual dose reduction (GDR) in the facility, please consider decreasing to: 1 mg at bedtime. [PLEASE NOTE: Per federal nursing facility regulations, this individual DOES NOT meet criteria for GDR to be deemed "clinically contraindicated" because a GDR has not yet been attempted in the facility.] Rationale for Recommendation - Antipsychotic medications are subject to gradual dose reductions and the</p>	F 329		



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F 329	<p>Continued From page 16</p> <p>manufacturer's prescribing information includes a BOXED warning which identifies a potential increased risk of mortality in elderly individuals taking antipsychotic medications for dementia-related behavioral disorders."</p> <p>CMS federal regulations documented the maximum daily dosage of Haldol recommended in the elderly population was 2 mg.</p> <p>On 06/17/11 Resident #57's primary physician checked the box on the Consultation Report which documented, "I decline the recommendation(s) above and do not wish to implement any changes due to the reasons DOCUMENTED BELOW." The report documented, "Please provide CMS (Center for Medicare and Medicaid Services) REQUIRED patient-specific rationale describing why a GDR attempt is likely to impair function or increase behavior in this individual." The primary physician replied "Not successful" to the recommendation.</p> <p>Resident #57's July 2011 Behavior Monitoring Form documented the resident was being monitored for agitation and her August 2011 Behavior Monitoring Form documented she was being monitored for yelling out, but failed to exhibit these behaviors.</p> <p>The resident's 08/29/11 Psychoactive Medication Evaluation documented dementia with behavior disturbances (anxiousness and agitation x 3 months) justified the use of Haldol.</p> <p>During the survey from 09/06/11 through 09/09/11 Resident #57 was not observed exhibiting any behaviors.</p>	F 329			

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F 329	<p>Continued From page 17</p> <p>At 10:13 AM on 09/08/11 Nurse #3 stated Resident #57 was very cooperative and appreciative of the care provided by the staff. However, she commented the resident exhibited childlike speech and behaviors since a stroke. The nurse commented sometimes the resident got loud, would yell to get the staff's attention, and became anxious when the staff could not immediately address her needs (crying and rocking back and forth in her wheelchair). She explained these behaviors were sporadic, and the resident did not refuse care and was not verbally or physically abusive toward staff or other residents.</p> <p>At 10:42 AM on 09/08/11 resident care specialist (RCS) #4 stated Resident #57 used baby talk, and would occasionally get anxious over such things as her hearing aides not working correctly. She commented the resident was a sweet lady, and did not refuse care and was not verbally or physically abusive toward staff or other residents. The RCS reported the resident could get loud at times, and could put up a fuss if the facility tried to put her to bed during the day because she liked to be up in her wheelchair.</p> <p>At 1:32 PM on 09/08/11 Nurse #4 stated Resident #57 used baby talk due to a stroke. She also reported the resident sometimes became loud and cried if family were not able to visit or she soiled herself before she could make it to the bathroom. The nurse commented these behaviors were sporadic, and the resident did not refuse care and was not verbally or physically abusive toward staff or other residents.</p>	F 329		
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F 329	<p>Continued From page 18</p> <p>At 4:40 PM on 09/08/11 RCS #5 stated Resident #57 did not refuse care and was not verbally or physically abusive toward staff or other residents. However, she reported the resident occasionally became anxious if things such as soiling herself or having to go to bed during the day hours occurred. When anxious, the RCS explained the resident made a whining noise, almost like she was crying.</p> <p>At 10:40 AM on 09/08/11 the MDS Nurse stated Resident #57 occasionally became anxious when her family was not able to visit or when they left the nursing home. She reported the resident became whiny when anxious. The MDS Nurse explained she thought some of the resident's anxiety was related to the resident's stroke and her hearing loss which frustrated her when she could not understand what people were saying to her.</p> <p>At 11:02 AM on 09/09/11, during a telephone conversation, the facility's Consultant Pharmacist stated sometimes Haldol was the medication of choice if residents were experiencing delirium or exhibiting continuous behaviors and the physicians wanted to preserve their current cognitive status. However, he commented Haldol used at very high doses was probably not the preferred line of treatment most of the time for the elderly population. According to the pharmacist, if physicians declined his requests for antipsychotic GDRs, he repeated the requests, but not necessarily at the next monthly medication reviews. He reported he remembered Resident #57's physician declining the Haldol GDR request. The Consultant Pharmacist stated sometimes these declined</p>	F 329		
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F 329	<p>Continued From page 19</p> <p>pharmacy recommendations were discussed at the facility's Medication Management Advisory Committee (MMAC) meetings.</p> <p>At 11:18 AM on 09/09/11, during a telephone conversation, Resident #57's primary physician stated after a stroke the resident exhibited the behaviors of crying, whining, and requesting to go home which was not possible. He reported he did not have the resident's medical record with him, but he believed the resident was discharged from the hospital on Haldol. He stated he did not prescribe Haldol a lot for his own patients, but it seemed as if hospitals were using it more frequently lately to manage behaviors. The physician explained if residents were discharged from the hospital on psychotropic medications, he usually left them on these medicines at least until the residents had a chance to adjust to their new nursing home environment. He commented he thought he had reduced Resident #57's dose of Haldol from what she was receiving in the hospital.</p> <p>At 11:35 AM on 09/09/11 the Director of Nursing (DON) stated Resident #57 did not refuse care, and was not verbally or physically abusive to staff or residents. However, she reported sometimes when the resident did not have her needs attended to immediately she became loud, whined, and tugged at staff. The DON commented she did not think the resident had a psychiatric diagnosis, only experiencing sporadic anxiousness. According to the DON, Haldol was probably not the best choice of medications in the elderly population because of a higher likelihood of adverse effects. However, she reported she thought the frequency of Resident #57's episodes</p>	F 329		
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F 329	Continued From page 20 of anxiety was reduced by use of the Haldol. The DON stated this was the resident's third stay in the facility, and the resident did not exhibit behaviors or receive Haldol during her other two stays. She commented she did remember the declined Haldol GDR request for Resident #57, but did not question it because she thought the resident was admitted to the facility from the hospital on Haldol. According to the DON, some physician responses to pharmacy recommendations and physician rates of declining the recommendations were discussed during the facility's quarterly MMAC meetings.	F 329		